

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-012572

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 251

Primary Registration District No. 3048

Registrar's No. 79

STATE FILE NUMBER

FILED APR 1 1963

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Nodaway	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Maryville		c. CITY OR TOWN Maryville	
Length of stay in 1b 10 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hospital		d. STREET ADDRESS (If outside, give location) 533 West Cooper	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle R. Last CARLSON		4. DATE OF DEATH Month 3 Day 24 Year 63	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/11/84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - retired		10b. KIND OF BUSINESS OR INDUSTRY Own account	
11a. FATHER'S NAME John Carlson		11b. MOTHER'S MAIDEN NAME Louise	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. [redacted]	
17. INFORMANT Mrs. Leona M. Carlson, Maryville, Mo.		18. NAME OF HUSBAND OR WIFE Leona M. Carlson	
19. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma from prostate to chest and brain		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Maryville, Missouri	
21. I attended the deceased from 9-4-61 to 3/24/63 and last saw him alive on 3-24-63		22. DATE SIGNED 3-27-63	
22a. SIGNATURE [Signature]		22b. ADDRESS Maryville, Missouri	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 3/27/63	
23c. NAME OF CEMETERY OR CREMATORY Nodaway Memorial Gardens		23d. LOCATION (City, town, or county) Maryville, Missouri	
24. FUNERAL DIRECTOR Price Funeral Home, Maryville, Mo.		25. DATE RECD. BY LOCAL REG. 3-27-63	
26. REGISTRAR'S SIGNATURE [Signature]		27. REGISTRAR'S SIGNATURE [Signature]	

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *GT Merrick*

Licensed Embalmer No. 5188
P. O. Address *Marionville Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.